STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
MEDICAL ASSISTANCE PROGRAM

Attachment 4.19-B

State NEW YORK

Description of the Policy and the Methods
to be Used in Establishing Payment Rates

The Division of Health Economics of the New York State Department of Health has been charged with the responsibility of studying and determining fees for providers of medical and paramedical care.

In pursuit of these fee studies, the Division of Health Economics meets with the representative professional groups, studies published and unpublished fee surveys, makes comparisons with schedules of insurance carriers and Workmen's Compensation, and conducts informal surveys as the occasion demands.

When the Division of Health Economics develops a fee schedule which approximates average prevailing fees in the State, a fee schedule and supporting position paper are sent to all members of the Interdepartmental Committee on Health Economics. This Committee is composed of representatives from the Departments of Education (Division of Vocational Rehabilitation, Social Services, Health, Mental Hygiene, Correction, Civil Service, Insurance, Workmen's Compensation and the Division of the Budget. The Committee may approve the schedule as presented or make modifications. The schedule is then recommended to the Commissioner of Health who, if in agreement, recommends approval to the Director of the Division of the Budget. The Budget Director may then approve and promulgate the schedule.

Promulgated schedules apply to all State programs except Workmen's Compensation, and supersede all existing schedules including those previously promulgated by the Department of Education, Health and Social Welfare.

Fees contained in the schedules are to be considered full payment of the services rendered. Under the Medical Assistance Program, which is administered by local welfare districts, these fees represent maximum allowances for purposes of State reimbursement. Each local welfare district may determine the fees paid to practitioners for services to eligible recipients.

Fees for services or procedures which are not included in the fee schedule may be determined on an individual basis by the appropriate public agency. However, such determinations must be reported promptly to the Division of Health Economics which reviews the fee for the given procedure and subsequently recommends a fee for approval by the Interdepartmental Committee on Health Economics and for possible incorporation in the fee schedule.

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TYPE OF SERVICE	METHOD OF REIMBURSEMENT
Physician Services	Fee Schedules developed by the Department of Health and approved by the Division of the Budget. For primary care and specialty physicians meeting the eligibility and practice criteria of and enrolled in the HIV Enhanced Fees for Physicians (HIV-EFP) program, and the Preferred Physicians and Children's program (PPAC), fees for visits are based on the Products of Ambulatory Care (PAC) structure: fees are based on recipient diagnosis, service location and visit categories which reflect the average amount of physician time and resources for that level of visit. The PAC fee structure incorporates a regional adjustment for upstate and downstate physicians. Reimbursement for the initial and subsequent prenatal care and postpartum visit for MOMS is the same as PPAC. Reimbursement for delivery only services and total obstetrical services for physicians enrolled in MOMS is fixed at 90% of the fees paid by private insurers. Ancillary services and procedures performed during a visit must be claimed in accordance with the regular Medicaid fee schedule described in the first paragraph above. HIV-EFP, PPAC and MOMS fees were developed by the Department of Health and approved by the Division of the Budget. Physicians providing methadone maintenance treatment in accordance with Article 33 of the Public Health Law are eligible to receive enhanced weekly fees for these services if they meet these criteria: 1. The physicians comply with the State Office of Alcoholism and Substance Abuse Services financial disclosure requirements; and 2. The physicians submit and the State approves their application to become designated as a Preferred Provider; The enhanced weekly fees are derived from provider-specific cost data. To the facility-specific amounts a fixed amount for urinalysis is added, then the weekly fees are averaged based on program census to yield a weighted average weekly fee for all participating physicians. The fees are calculated by the State Department of Health subject to approval of the State Division of the Budget.

Type of Service	Method of Reimbursement
Dental Services (including dentures)	Payments are limited to the lower of the usual and customary charge to the public or the fee schedule developed by the Department of Health and approved by the Division of the Budget,
Podiatrists	Fee schedule developed by the Department of Health and approved by the Division of the Budget.
Optometrists	Fee schedule developed by the Department of Health and approved by the Division of the Budget.
Chiropractor's Services	Fee schedule developed by the Department of Health and approved by the Division of the Budget.
Nurse Midwives	Fee schedule developed by the Department of Health and approved by the Division of the Budget.
Nurse Practitioners	Fee schedule developed by the Department of Health and approved by the Division of the Budget.

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Other Practitioner Services

Clinical Psychologists	Fee schedule developed by the Department of Health and approved by the Division of the Budget.

Outpatient Hospital Services/Emergency Room Services

For those facilities certified under Article 28 of the State Public Health Law: The Department of Health promulgates prospective, all inclusive rates based upon reported historical costs. Allowable operating costs per visit are held to legislatively established ceiling limitations. Reported historical operating costs on a per visit basis, which are below or limited by ceilings, are deemed reimbursable and trended forward to the current rate period to adjust for inflation. Non operating costs (such as capital costs) are not subject to the legislatively established ceiling and are added to the product of reimbursable operating costs times the roll factor

(two year trend movement) on a per visit basis, except that commencing April 1, 1995 for rates of payment for patients eligible for payments made by state governmental agencies, the capital cost per visit components shall be adjusted by the commissioner to exclude such expenses related to 1) forty-four percent of the costs of major moveable equipment and 2) staff housing. A return on equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Renal dialysis services are reimbursed on the lower of a facility's actual cost or Statewide ceiling of $150.00 per procedure. Payment rates for renal dialysis services are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. [All rates are subject to approval by the Division of the Budget.] Effective October 1, 1995, the rate for primary care clinic services provided in primary care hospitals, shall be a per visit rate based on allowable reportable operating costs subject to a cap on operating costs of $67.50 per visit. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however that the capital cost per visit components shall be adjusted by the commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return in equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

Effective October 1, 1995, the rate for emergency services provided in primary care hospitals, shall be a per visit rate based upon allowable reportable operating costs and limited to a cap on operating costs of $95 per visit. Allowable reportable capital costs will be reimbursed on a per visit basis not subject to a ceiling on reimbursement, provided however, that the capital cost per visit components shall be adjusted by the commissioner to exclude such expenses related to 1) forty-four percent of the cost of major movable equipment and 2) staff housing. A return in equity is recognized in those instances where the hospital is organized under the auspices of proprietary sponsorship.

All rates are subject to approval by the Division of the Budget. For emergency room services only, a retrospective adjustment may be made if it is determined that patients requiring general clinical services are provided such services in the emergency room for the sole purpose of maximizing reimbursement.

Designated Preferred Primary Care Provider for Hospital-Based Outpatient Clinics and Hospital-Based Specialty Clinic Services

Hospital-based clinics seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health. Providers seeking reimbursement for certain outpatient specialty clinic services are required to document in writing and through site inspection or records review that they are in fact organized as and providing specialty services.

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Reimbursement for providers designated as preferred primary care providers or for hospital based programs providing specialty clinic services is prospective and associated with resource use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system.

Under the reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service, a rate is established to cover all labor, ancillary services.

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medical supplies, administrative overhead, general and capital costs. The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor.

For services provided on or after April 1, 1995 [~~The reimbursement payment method for~~] by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement payment methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating hospitals. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

Ordered Ambulatory Services (specific services performed by a free-standing clinic on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient)

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate.

Payment for these services will not exceed the combined

payments received by a provider from beneficiaries and carriers or intermediaries for providing comparable services under Medicare.

Freestanding Clinic Services (diagnostic and treatment facilities) Facilities Certified Under Article 28 of the State Public Health Law; Including Federally Qualified Health Centers

Prospective, all inclusive rates calculated by Department of Health, based on the lower of the allowable average cost per visit or the group ceiling trended to the current year. For purposes of establishing rates of payment for diagnostic and treatment centers for services provided on or after April 1, 1995, the reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Facilities offering similar types of services and having similar regional economic factors are grouped and ceilings are calculated on the cost experience of facilities within the group taking into account regional economic factors such as geographic location. Costs at or below these ceilings have been determined to be reasonable. The rates include a

capital cost component. For fiscal year ending March 31, 1994, such rates are trended and extended to September 30, 1994. Commencing October 1, 1994 and thereafter, such rates shall be calculated as above for fiscal years beginning October 1, and ending September 30 except that rates of payment ending September 30 for the period ending 1995 shall continue in effect through September 30, 1996. MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Payment rates for renal dialysis services of $150.00 per procedure are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. A single price per visit for day health care services rendered to patients with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses is determined based on reasonable projection of necessary costs and utilization and trended to later rate years. Price components may be adjusted for service capacity, urban or rural location and regional differences. Rates are subject to approval of the Division of the Budget.

Designated Preferred Primary Care Provider for Freestanding Diagnostic and Treatment Centers

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Freestanding diagnostic and treatment centers seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health.

Reimbursement for providers designated as preferred primary care providers is prospective and associated with resources use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system.

Under the reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service a rate is established to cover all labor, ancillary services, medical supplies, administrative overhead, general and capital costs. A supplemental capital add on is available to facilities participating in the preferred primary care program which finance capital acquisitions through public authorities.

The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor, except that rates of payment for the period ending September 30, 1995 shall continue in effect through September 30, 1996. A supplemental bad debt and charity care allowance will be established annually for diagnostic and/or treatment centers approved as preferred primary care providers and paid as an addition to the facility's rate of payment. Each facility's allocation shall be based on its losses associated with the delivery of bad debt and charity care and computed on the basis of projected and allowable fiscal and statistical data, adjusted to actual, submitted by the facility. The amount paid per visit shall be based on each facility's allocation divided by projected Medicaid threshold visits adjusted to actual visits.

For services provided on or after April 1, 1995 [The reimbursement payment method for] by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a diagnostic and treatment center operated by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement payment methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating diagnostic and treatment centers. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial

responsibility of providers for selected laboratory and other ancillary procedures and Medicaid revenue assurances. Financial incentives are employed (within limitations) under this system to assure that these and other features are complied with.

Ordered Ambulatory Services (specific services performed by a free-standing clinic on an ambulatory basis upon the order of a qualified physician, physician's assistant, dentist or podiatrist to test, diagnose or treat a recipient or specimen taken from a recipient).

Fee schedule developed by the Department of Health and approved by the Division of the Budget for each type of service, as appropriate.

Payment for these services are in compliance with 42 CFR 447.325.